(B) the payment of a monthly per beneficiary premium by each 1988 last signatory operator for each eligible beneficiary of such operator who is described in subsection (b)(2) and who is receiving benefits under the 1992 UMWA Benefit Plan, and

(C) the provision of security (in the form of a bond, letter of credit or cash escrow) in an amount equal to a portion of the projected future cost to the 1992 UMWA Benefit Plan of providing health benefits for eligible and potentially eligible beneficiaries attributable to the 1988 last signatory operator. If a 1988 last signatory operator is unable to provide the security required, the 1992 UMWA Benefit Plan shall require the operator to pay an annual prefunding premium that is greater than the premium otherwise applicable.

(2) Adjustments

The 1992 UMWA Benefit Plan shall provide for—

(A) annual adjustments of the per beneficiary premium to cover changes in the cost of providing benefits to eligible beneficiaries, and

(B) adjustments as necessary to the annual prefunding premium to reflect changes in the cost of providing benefits to eligible beneficiaries for whom per beneficiary premiums are not paid.

(3) Additional liability

Any last signatory operator who is not a 1988 last signatory operator shall pay the monthly per beneficiary premium under paragraph (1)(B) for each eligible beneficiary described in such paragraph attributable to that operator.

(4) Joint and several liability

A 1988 last signatory operator or last signatory operator described in paragraph (3), and any related person to any such operator, shall be jointly and severally liable with such operator for any amount required to be paid by such operator under this section.

(5) Deductibility

Any premium required by this section shall be deductible without regard to any limitation on deductibility based on the prefunding of health benefits.

(6) 1988 last signatory operator

For purposes of this section, the term ''1988 last signatory operator'' means a last signatory operator which is a 1988 agreement operator.

(Added Pub. L. 102–486, title XIX, § 19143(a), Oct. 24, 1992, 106 Stat. 3053.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(C), (D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Title XVIII of the Act is classified generally to subchapter XVIII (§ 1395 et seq.) of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 9701, 9711 of this title.

Subchapter D—Other Provisions

§ 9721. Civil enforcement

The provisions of section 4301 of the Employee Retirement Income Security Act of 1974 shall apply to any claim arising out of an obligation to pay any amount required to be paid by this chapter in the same manner as any claim arising out of an obligation to pay withdrawal liability under subtitle E of title IV of such Act. For purposes of the preceding sentence, a signatory operator and related persons shall be treated in the same manner as employers.

(Added Pub. L. 102–486, title XIX, § 19143(a), Oct. 24, 1992, 106 Stat. 3055.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in text, is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 829, as amended. Subtitle E of title IV of the Act is classified generally to subtitle E (§ 1381 et seq.) of subchapter III of chapter 18 of Title 29, Labor. Section 4301 of the Act is classified to section 1451 of Title 29. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

§ 9722. Sham transactions

If a principal purpose of any transaction is to evade or avoid liability under this chapter, this chapter shall be applied (and such liability shall be imposed) without regard to such transaction.

(Added Pub. L. 102–486, title XIX, § 19143(a), Oct. 24, 1992, 106 Stat. 3056.)

Subtitle K—Group Health Plan Requirements

AMENDMENTS

1997—Pub. L. 105–34, title XV, § 1531(a)(1), Aug. 5, 1997, 111 Stat. 1080, struck out ''Portability, Access, and Renewability'' before ''Requirements'' in subtitle heading and made similar change in item for chapter 100.

SUBTITLE REFERRED TO IN OTHER SECTIONS

This subtitle is referred to in title 42 section 1397ii.

CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

AMENDMENTS

1997—Pub. L. 105–34, title XV, § 1531(a)(1), Aug. 5, 1997, 111 Stat. 1080, struck out ''PORTABILITY, ACCESS, AND RENEWABILITY'' in chapter heading and added analysis for chapter.

CHAPTER REFERRED TO IN OTHER SECTIONS

This chapter is referred to in sections 4980B, 4980D of this title; title 29 section 1162; title 42 section 300bb–2.

[1] Section number editorially supplied.

[1] Section numbers editorially supplied.

Subchapter A—Requirements Relating to Portability, Access, and Renewability

AMENDMENTS

1997—Pub. L. 105–34, title XV, §1531(a)(1), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and items 9801 to 9803 and struck out former items 9801 ''Increased portability through limitation on preexisting condition exclusions'', 9802 ''Prohibiting discrimination against individual participants and beneficiaries based on health status'', 9803 ''Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements'', 9804 ''General exceptions'', 9805 ''Definitions'', and 9806 ''Regulations''.

§ 9801. Increased portability through limitation on preexisting condition exclusions

(a) Limitation on preexisting condition exclusion period; crediting for periods of previous coverage

Subject to subsection (d), a group health plan may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions

For purposes of this section—

(1) Preexisting condition exclusion

(A) In general

The term ''preexisting condition exclusion'' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

For purposes of this section, genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term ''enrollment date'' means, with respect to an individual covered under a group health plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term ''late enrollee'' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) Waiting period

The term ''waiting period'' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) Creditable coverage defined

For purposes of this part, the term ''creditable coverage'' means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act.

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

(E) Chapter 55 of title 10, United States Code.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5, United States Code.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 9832(c)).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).